Child Survival
CONNECTIONS
Spring 2001

Success, Innovations, and Promising Practices from Projects Around the World

Evaluation Results Highlights Issue

Introduction

The most recent Evaluation Guidelines from the BHR/PVC Child Survival Grants Program suggested that PVOs include a Results Highlight, "a one-page description of some element of the program, with supporting data, that would make a good stand-alone communication piece for the PVO or USAID to distribute or to post on the Office WebPage."[1]

This issue of CS Connections features select Results Highlights from CS XII final evaluations and CS XIV midterm evaluations. These Highlights provide a glimpse into a variety of child survival projects around the world. They are presented not as "how-to" articles, but as short updates on what projects in the Child Survival Grants Program are doing and what they consider to be their successes.

As you will notice, some Highlights are longer than others. Some emphasize numbers while others emphasize process. Some discuss several interventions, and some concentrate on only one or two interventions. All of the highlights included here do have two things in common: they are all taken from CSGP evaluation reports, and they all include contact information for anyone who may want further information.

We hope you enjoy reading about the projects featured here, and that these examples lead to further discussions between PVOs about the range of approaches in PVC's CS portfolio. We look forward to publishing additional Results Highlights supplements in the future.

[1]USAID/BHR/PVC PVO Child Survival Grants Program CS-XIV, 1998-2002 "Guidelines for Mid-Term Evaluation" (Issued May 2000), 15.

CARE Haiti: Increasing Contraceptive Use

CARE's RICHES 2000 project in rural Haiti was instrumental in achieving high levels of contraceptive prevalence despite a deteriorating community-based contraceptive distribution network. Comparison of baseline and final Knowledge, Practices and Coverage (KPC) surveys conducted in the remote and rural area of the Grand Anse region of Haiti covered by the RICHES 2000 project indicate that use of contraceptives rose from 20 percent to 33 percent of all women aged 15-49 years of age. This is especially impressive when compared to national estimates of contraceptive prevalence of approximately 15 percent. Clearly, the RICHES 2000 strategy of combining community mobilization and education with efforts to strengthen the delivery of key women's health services at health facilities in the region has contributed to this important result. The results are all the more impressive considering that the Ministry of Public Health and Population (MSPP) had, for largely financial reasons, withdrawn support for its network of rural, community based agents de sante (community health agents). These agents had been the foundation for MSPP efforts to increase access to modern contraceptives as distribution points for contraceptives (mainly condoms and pills).

Efforts to improve the availability of services werecoupled with aggressive and innovative community mobilization and communication activities intended to increase the demand for those services.

At its inception the RICHES 2000 project sought to increase contraceptive use in its eight communes in rural Grand Anse region. The project supported the community health agents and improving the capacity of the fixed health facilities in the area to deliver family planning services. These efforts to improve the availability of services were coupled with aggressive and innovative community mobilization

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CARE Haiti...

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and communication activities intended to increase the demand for those services.

At the same time as RICHES 2000 was improving the availability of all methods of modern contraception (including clinic-based methods) a shift in client preference was occurring. More and more women were choosing injectable contraceptives (Depo-Provera) over other methods. These methods were available only at clinics. This shift in preference then coincided with RICHES 2000's efforts to improve their availability at the fixed facilities in the area. This shift in preference is seen in RICHES 2000 KPC results which show an increase in overall contraceptive prevalence and a shift towards the use of injectable contraceptives (36 percent of women practicing family planning at baseline used injectables as compared to 51 percent four years later).

For more information on CARE's CS XII project in Haiti, please contact:

- Namita Kukreja, Children's Health Program Associate, CARE: kukreja@care.org
- Pascale Crussard, CARE Haiti: crussard@pap.care.org

The Living University: Addressing Community-Defined Problems, Disseminating Healthy Practices, and Scaling-Up Child Survival Activities in Upper Egypt

The Living University approach was developed by Save the Children (SC) in Vietnam as a mechanism for program expansion and for fostering local capacity to implement and sustain development projects, built on the principle of "learning by doing." The LU began in a few communities to pilot and closely monitor an innovative nutrition program. Upon demonstrating measurable effects, the initial site became a "Living University," a "laboratory" where those wishing to learn about the program actively participated in its protocols and activities. Upon "graduation," LU students returned home and began program implementation. After refinement, their areas became LUs, from which further expansion occurred. This approach enabled the SC nutrition program to expand from a population of 40,000 to 1.5 million, while maintaining program quality and impact.

In Upper Egypt, through the USAID Mission-funded "Partnering for Institutional Development" (P/ID) project in Minya Governorate, the LU has enabled Community Development Associations (CDAs, government registered local NGOs) to plan, implement, and manage economic opportunity, education, early childhood development, and primary health programs, employing local expertise and resources.

This approach enabled the SC nutrition program to expand from a population of 40,000 to 1.5 million, while maintaining program quality and impact.

SC's child survival project in Minya (CS-14) is employing this successful model to address community-defined problems, disseminate healthy practices throughout communities, and scale-up the project to reach new areas. Currently, three experienced LU CDAs from the P/ID Project are training and supporting three new CS-14 "Learner" ("LR") CDAs to assess health needs, to mobilize communities, and to plan and manage development activities. Each CDA receives a sub-grant from SC, with each LU CDA mentoring one LR CDA. LU CDAs and SC are working with LR CDAs to train, support, and monitor female Community Health Workers (CHWs) to provide CS services in their communities, and to link these community health

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Health Promoter Associations: A Strategy for Sustainability CARE/Project Enlace

By Rachael McClennen[1]

Introduction

The sustainability of any child survival project is an issue of great concern for project staff and funding agencies from the outset. Typically, such projects enter a certain geographical area and train volunteer community health promoters[2] in interventions such as diarrheal diseases, respiratory infections, maternal health, breastfeeding, immunizations, and nutrition, among others. The project coordinates with the Ministry of Health (MOH) in order to increase the sustainability of the health promoters' work when the project has left the area. The expectation at the completion of the project is that the MOH and the health promoters have attained a solid working relationship and the necessary skills to ensure that the work will continue.

Two issues affect the ability of Ministries of Health in sustaining the efforts of community health volunteers. The first is that of resources. Rarely does the MOH have funds to provide refresher training for the volunteers or to recruit and train new volunteers. Nor do Ministry staff have time and transportation to travel to communities to maintain supervision and communication with the promoters. Secondly, there is the issue of MOH perception of the value of community volunteers' work in relation to the amount of effort required to support them. Without MOH support, training and supervision, volunteers soon lose their motivation and cease participating. Desertion rates in excess of 50% are common when PVOs withdraw.

When the link between the MOH and the health promoters is not strong enough, and leadership and self-sufficiency of the volunteers not fully developed, the end result is less health impact than expected, unsustained behavior changes, disillusioned health promoters, unsatisfied MOH personnel, and wasted money.

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CARE's Proyecto Enlace[3] (Project Link) in the highlands of La Libertad region of northern Peru has used a strategy of forming and strengthening Health Promoter Associations (APROMSAs) that will greatly increase the level of sustainability of volunteers. As the project nears its end, it is clear that the APROMSAs and the MOH have gained the necessary skills and credibility in their communities to elaborate annual operating plans, including supervision and activities that allow for generating funds. This allows for complete self-sufficiency of the health promoter associations, which in turn leads to better-developed communities, active health promoters, and satisfied MOH personnel.

This report gives the history of APROMSAs in Peru, explains how Project Enlace has used and strengthened their presence, and what lessons CARE has learned that it can apply to future child survival projects.[4] By taking advantage of this strategy, other child survival projects will be even more sustainable because they will leave self-sufficient institutions working together with the MOH to improve health in rural communities.

[1] This was originally written as part of an internship experience for a Masters in Public Health, Harvard School of Public Health in the summer of 1999. This current version was edited by Judiann McNulty, DrPH, Deputy Director for Children's Health at CARE, USA in September, 2000.

[2] The terms *volunteer* and *promoter* are used interchangeably in this document.

[3] Project *Enlace* was funded by CARE and USAID under a grant from BHR/PVC for Child Survival XII.

[4] As of September, 2000, the APROMSA strategy of CARE is being adopted by the Ministry of Health of Peru as an essential component of their community program for other regions of Peru.

History of Health Promoter Associations in Peru

The oldest APROMSA in Peru was formed in 1980 in San Marcos, Cajamarca. In 1979, the Catholic Church trained a number of health promoters from nearly 50 communities in various health interventions. Because the promoters soon felt that their activities were not well coordinated with each other, they decided to join together to form an association, in hopes of being more easily recognized by their communities, the MOH, non-governmental organizations (NGOs), and the state. At that time, they formed a board of directors that had the responsibility of overseeing its approximately 80 members.

The Catholic Church was only one of the institutions to help form and strengthen the APROMSA San Marcos. The APROMSA also had a large amount of support from MOH personnel, in particular Dr. Alfonso Nino Guerrero, who was on staff from 1980 to 1984. Although the APROMSA members received no formal leadership training, they were empowered by Dr. Nino, which has aided them to continue to be an organized institution despite his later absence. In addition, the APROMSA received support from various organizations such as UNICEF, CARE, CEDAS/IDEAS, and APRISABAC. The various NGOs, the MOH, local governments, and the Catholic Church each helped to support the training of the APROMSA members and its board of directors in various health interventions and limited accounting principles. They have also donated materials and logistical support for training, such as transportation and meals and educational materials for promoters to use in their communities.

It was not until 1995 that APROMSA San Marcos decided to obtain legal status, including a constitution and bylaws. The board of directors chose to apply for legal status in order to more easily solicit funding, material, and logistical support. Having official legal status has improved the reputation in the communities, allowed organized coordination with the MOH, and in turn created a more efficient APROMSA.

Current APROMSA San Marcos

Currently, the APROMSA San Marcos is a well-established and respected institution. It has a house that serves as a meeting place for the board of directors, and as a place to receive patients with a small pharmacy. The house is currently being renovated for the purpose of adding a community soup kitchen and small hotel. The board of directors hopes to generate enough funds to be able to support the cost of a telephone and vehicle.

The board of directors is comprised of a president, vice-president, treasurer, secretary, finance officer, and various minor officers. The health promoters elect a new board of directors every two years. The board meets about every two months in order to review the work of the health promoters, and to follow up on fundraising and financial issues. In addition to the board of director meetings, all members of the APROMSA meet twice a year for workshops, refresher courses, and to address financial issues. Underneath the board of directors, three coordinators are responsible for overseeing the work of the promoters in their geographical region.

In addition to having promoters in each community who are in charge of disseminating health messages to community members, the APROMSA produces a daily radio hour and holds health fairs to educate the community.

The APROMSA San Marcos organizes various activities in order to improve health in its communities and to generate funds to support the APROMSA. In addition to having promoters in each community who are in charge of disseminating health messages to community members, the APROMSA produces a daily radio hour and holds health fairs to educate the community. Also, the APROMSA has received a loan in the amount of approximately $2000 from a local NGO. The APROMSA has used those funds to begin a rotating fund that its members can use for personal investments, such as seeds, tools, land, etc. The interest that the APROMSA

makes from those loans is used to help finance things such as food and transportation during the refresher courses that the MOH gives. The APROMSA also continues to apply for funds and receive support from the MOH, NGOs, and local governments. In addition to health activities, the APROMSA takes part in regular multi-sector meetings in the communities, as well as round- table discussions to address specific development issues.

In spite of APROMSA San Marcos' overall operational efficiency, the organization contends with various obstacles. Members of the board of directors admit that they lack certain skills to be able to continue to grow and provide development in their communities. For example, although they have received some training in accounting principles, they desire more to better track their rotating fund. In addition, they admit that they lack skills in managing paperwork, administering projects, and fundraising. Structurally, the APROMSA San Marcos has its weaknesses as well. For example, its structure is such that there is one board of directors and three coordinators who try to oversee the work of all of the health promoters. This has limited their capacity to provide supervision and support to all members.

APROMSAs of Project *Enlace*

When Project *Enlace* began its work in the La Libertad region in October of 1996, two of the current five APROMSAs were already loosely formed by a previous CARE water and sanitation project in the early 1990s. They were modeled after the San Marcos experience. APROMSA Usquil did not have a legal constitution, bylaws, accounting books, or legal recognition by the government Although the APROMSA Otuzco had legal status, it was not sufficiently organized and active. These two APROMSAs were organized in such a way that the members had been working together as a group of promoters for the duration of the water and sanitation project, yet following the project their coordination was somewhat weak.

Because the APROMSAs did not have recognition throughout the community, the MOH and the local governments were reluctant to recognize their possible advantages of improving the health of the population. Project Enlace focused on strengthening those two APROMSAs, in addition to forming and strengthening three new APROMSAs in the project area, as one of its strategies of sustainability. Each APROMSA covers a geographical area known as a "micro-network." Because the MOH's jurisdiction of the project area is divided into five micro-networks, three additional APROMSAs have been formed, and the two existing ones strengthened. At the level of each micro-network, there is one main health center and various smaller health posts.

In addition to educating the promoter members in the specific health interventions of the child survival project, Enlace trained the APROMSA boards of directors in skills pertaining to management.

Essential Steps for Successful APROMSAs

Project *Enlace* has used a variety of strategies to form and strengthen the five APROMSAs. In addition to educating the promoter members in the specific health interventions of the child survival project, *Enlace* trained the APROMSA boards of directors in skills pertaining to management.

1. Selection of the Volunteers

At the beginning of the project, Enlace held meetings in each of the project communities to help facilitate the communities' process for identifying potential community leaders. Once the health promoters were selected, or existing promoters reaffirmed, Enlace trained the MOH staff to train the promoters and began to form and strengthen the APROMSAs. This process allowed the MOH to build a direct relationship with the promoters.

2. Training of the APROMSA Health Promoters

All of the health promoters began receiving training from MOH personnel in the interventions of the Project Enlace: diarrheal case management, respiratory infection case manage-

ment, maternal health, breast-feeding, and methodology in adult education. Trainings were organized in a decentralized manner. Each health unit (post or center) trained its corresponding APROMSA members, allowing for better communication and mutual understanding between the APROMSA members and MOH personnel.

The principal objective of forming and strengthening the board of directors of the COPROMSAs is to provide support and supervision to the health promoters in each cluster of communities.

3. Formation of the APROMSA

Even as the promoters began receiving their technical training, the organization of the APROMSA began. The first step, an innovation of Enlace, was to organize local groups around each health unit. These groups are called COPROMSAs for Committees of Health Promoters.

The purpose of the COPROMSA is to allow for close coordination and supervision of the promoters among themselves and to serve as a channel of communication with local MOH personnel. In each COPROMSA, a board of directors was elected, including a president, secretary, treasurer, and vocal. Once the boards of directors of all of the COPROMSAs were formed, board members met at the micro-network level to discuss and propose statutes which would be used in the APROMSA's constitution. (Normally, each APROMSA is made up of about five COPROMSAs, depending on the number of health facilities in the micro-network). The proposed statutes developed by the boards of directors of the COPROMSAs were then shared with all of the health promoters of that APROMSA, and the board of directors developed the constitution based on the agreed-upon statutes. The health promoters met and agreed upon and signed the constitution, thus formalizing the APROMSA.

Once the constitution was signed, an electoral committee was formed to aid in the election of the board of directors of the APROMSA. The electoral committee decided upon the voting process, and then carried out the election, by process of secret vote, of the APROMSA's president, vice-president, finance officer, secretary, and treasurer. In addition, the president of each COPROMSA represents his/her COPROMSA within the APROMSA.

Upon the election of the board of directors of the newly formed APROMSAs, they began a fundraising process in order to pay for the registration of the institution with the government. Upon acquiring the necessary funds, the board of directors of the APROMSA was then able to take the constitution to a public registry in order to gain legal status.

APROMSA and COPROMSA Primary Roles

The principal objective of forming and strengthening the board of directors of the COPROMSAs is to provide support and supervision to the health promoters in each cluster of communities. Members of the COPROMSA board, on a regular schedule, visit the other health promoters in their communities to observe their work with community members, give advice regarding how to improve their work, and address any questions that the promoter may have. In addition, the COPROMSA makes an annual operating plan with the local health staff and coordinates participation of the health promoters in health promotion events carried out as a group.

The primary role of the APROMSA board is to raise funds for activities and keep the APROMSA and COPROMSAs active. This includes establishing and maintaining strong relations with municipal authorities and micro-network health officials. In addition, the APROMSA board of directors also serves a supervisory and supportive role over the COPROMSA board. In order to oversee the APROMSAs, the various presidents of the APROMSAs have formed themselves into an informal supervisory committee to supervise each APROMSA. This system allows for mutual support, continual sharing of experiences and efficient problem-solving.

4. Training of the APROMSA Leaders

Once the board of directors of the APROMSA was selected, Enlace began trainings to strengthen the APROMSA leaders and the MOH personnel. (The MOH personnel desig-

nated to work with the health promoters needed to learn the organizational and management skills necessary to support the APROMSAs and to train future leaders.) In order to address the areas that needed the most strengthening, Enlace staff held a workshop with the board of directors of the APROMSAs (including the president from each COPROMSA who has the job of representative to the APROMSA) and key MOH personnel. In the workshop, they identified needs for training that would allow them to have a self-sustaining APROMSA and an empowered MOH. They also discussed possible visions for their institutions, including the role that each functionary would play. All members of the boards of directors of each APROMSA and each manager at the micro-network health center level began receiving workshops. The themes that the participants identified, and in which they were subsequently trained, included the following: accounting principles, supportive supervision, communication skills, how to work in teams, leadership, fundraising skills, gender issues, facilitation, training of trainers, self-esteem building, management, project design, and how to formulate, evaluate, and monitor an annual operating plan.

These skills were taught in workshops given by Enlace, other CARE staff, and outside consultants. For example, in the case of accounting principles, one of the CARE accountants facilitated the workshop. In the case of the leadership workshops, an outside consultant was hired to facilitate. The complete boards of directors of the APROMSAs took part in the workshops along with the manager of each head health center. The workshops usually lasted two or three days, and they were more centralized than the workshops that the MOH facilitated, in that they were based in a central location as opposed to the communities. In addition to this format being logistically effective, it also allowed for APROMSA leaders to share their experiences with others. They were able to learn about each others' difficulties, challenges and successes. As a step towards sustainability, from the beginning, costs of the training were shared by CARE, the MOH, and APROMSAs.

In addition, Enlace implemented meetings of all APROMSAs on a bi-monthly basis to allow the leaders of the COPROMSAs and APROMSAs to exchange their successes, challenges, and lessons learned. This proved to be extremely valuable because it allowed the leaders to motivate and support each other.

In addition to formal workshops addressing the previously listed themes, Enlace staff members made frequent visits to the health centers to be able to reinforce the skills taught in the workshops, both at the level of the MOH and with the boards of directors of the APROMSAs and the president of each COPROMSA. Enlace staff monitored the elaboration of the APROMSA's annual operating plan, utilized opportunities to give and receive feedback, reinforced leadership skills, encouraged teamwork, gave advice for fundraising and managing of funds, etc.

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Currently, the COPROMSAs and APROMSAs have well-defined visions and work plans that correspond with MOH goals. These work plans are made in conjunction with the MOH and municipal government. The APROMSAs coordinate with the MOH and local governments in planning health fairs, radio programs, refresher courses, and plays for community members.

All members of the COPROMSAs typically meet once a month with MOH personnel to present and discuss reports, solve problems, evaluate progress toward the work plan, and plan future activities. Usually, the board of directors of the APROMSAs meets once a month with MOH staff, and with all the promoters every three months. New boards of directors are elected every two years.

Benefits of APROMSAs

The advantages of having organized and active APROMSAs superceded the expectations of Enlace staff. One of the most positive out-

comes of the presence of APROMSAs has been greater respect of promoters on the part of the local government, the MOH, and NGOs. By observing MOH staff and promoters interact, one can note the mutual respect that each hold in the work environment. APROMSA members note that the MOH appreciates promoters' work because it leads to increased coverage, increased use of health services and improved health behaviors. The MOH is particularly pleased to have the accurate census data that promoters continually update. MOH personnel are also more aware of the fact that health promoters are volunteers, and have come to value their work to a larger degree.

In turn, the personal relationship between promoters and health personnel has resulted in the health personnel leaving the clinics more often to provide services and education in the communities and visit patients in their homes. When health staff travel to a village, they know they will be met by the volunteer, presented to the households they need to visit, and accompanied in their activities. They also know they can send word to the promoter to follow up on specific patients. The MOH staff state that it is much easier to plan and work with the promoters as an organized group rather than as disperse individuals when it comes to arranging for training, meetings, or other organized events.

One of the most positive outcomes of the presence of APROMSAs has been greater respect of promoters on the part of the local government, the MOH, and NGOs.

APROMSAs have asked for and received financial or logistical support from their local governments in their work activities. Two have already been successful in acquiring donated land to build a place for training and meetings. Another has successfully negotiated with the municipal government to provide food for future training workshops. Because they recognize that health is not the only issue in development work, they participate in multi-sector committees in their communities. The APROMSAs also have plans for soliciting support from NGOs and government institutions and well as regular fund-raising activities such as raffles, barbecues, etc. All APROMSAs were given motorcycles by CARE's water and sanitation project, which they use to provide supervision and attend provincial meetings. However, they now must use some funds that they generate in order to pay for maintenance and gas of the motorcycles.

APROMSA leaders comment that they have gained greater respect within their communities. Although in the beginning stages of their work, community members only searched them out for free medicines, the people now have come to understand that the role of the promoter is more of a preventative one. They have come to see the difference that the health promoters are making in their community. In addition, the leaders of the APROMSAs and COPROMSAs note the personal satisfaction of being leaders in their communities. They have the advantage of learning how to manage an organization and how to participate in fundraising

The MOH staff state that it is much easier to plan and work with the promoters as an organized group rather than as disperse individuals when it comes to arranging for training, meetings, or other organized events.

The promoters have also made personal gains as a result of their involvement. Some have become active in helping plan civic events, others have become members of the Local Committee of Health Administration (CLAS), health advisors to mayors, literacy teachers, nursing students, and secondary school students. Such impressive personal and professional growth among APROMSA leaders was an unexpected result in the strategy of forming and strengthening APROMSAs.

A major advantage of the formation of the APROMSAs is that there is a better flow of communication among the promoters, continuous supervision, and therefore more effective outcomes. Leaders of the APROMSAs believe that having their own system of supporting and supervising health promoters leads to more active promoters and less drop outs. Because the promoters are continuously given feedback and support, they are more motivated to continue working and improving their skills. The desertion rate among promoters after four years is 12%, almost entirely attributable to migration from the area.

Board members of the APROMSAs also comment on the importance of meeting with and having exchanges with other APROMSA leaders. They are able to give each other suggestions, share successes, and problem solve together.

Challenges that APROMSAs Face

APROMSA leaders identify very few disadvantages that they face in light of being part of an organized institution. Even though membership in the COPROMSA and APROMSA requires even more donated time, members do not see that as a problem. In fact, Enlace and the MOH have observed that the promoters who devote the most time to their community activities are the same ones who are most willing to accept an elected position or committee assignment in their APROMSA.

On an institutional level, the principle challenges are maintaining commitment of the individuals to the organizations, and the constant quest for funds to support operation and activities. The leaders feel these challenges can be dealt with by continually reconfirming the purpose of the organization in order to motivate the membership.

Board members of the APROMSAs also comment on the importance of meeting with and having exchanges with other APROMSA leaders. They are able to give each other suggestions, share successes, and problem solve together.

Current Sustainability Situation

The APROMSA leaders state that when Enlace leaves the project area, they will continue to function as they have been functioning currently. They already have the skills and the experience to be able to successfully solicit funds and logistical support from local governments, the MOH, and other NGOs.

Very important to sustainability is the mutual commitment with the MOH. The APROMSAs have very strong relationships with the current MOH personnel at the level of each health unit. Two of the micro-reds have signed agreements with the APROMSA and the municipal government to support the APROMSA and the work of the promoters. In addition, the district health administration (UTES-8) has written a resolution pledging on-going support of the APROMSAs and their work.

Lessons Learned

Interestingly enough, those who state that the transition to post-Enlace work will be challenging are the COPROMSA leaders, not including the presidents. They are the leaders who have not received the same workshops that the APROMSA leaders received, such as leadership, fundraising, accounting principles, etc. This is an important issue to consider in future replication. It will be most effective to train all APROMSA and COPROMSA members for the most sustainable results.

Because the exchanges of experiences have proven to be so useful to APROMSA and COPROMSA leaders, it may be helpful to hold more formal events in the future. Such opportunities for sharing experiences allow for peer support and encouragement.

Another important lesson that Enlace staff have learned is the importance of involving female leaders, such as midwives and members of the mother's club, in APROMSA activities. Because the percentage of female promoters is between 35% to 40%, it is important to involve other female leaders from the communities. In future projects, other strategies to involve women in the project could be found, for example, increasing the quantity of female health promoters or by fully incorporating other female leaders in the communities.

Like any well-organized institution, APROMSA should also have a written vision that is defined by the promoters. By having a future to work towards, the APROMSA membership is more likely to be active in activities and fundraising.

Conclusion

Project Enlace's strategy of forming and empowering health promoter associations has proven to be a sustainable way to ensure active, efficient, and effective promoters when the project is no longer in the area. It allows for a self-sufficient institution that now has the skills to manage its own members, solicit funding from outside institutions, and to continually make a difference with respect to the health of their community members. The APROMSA model must not be limited to isolated projects. It has potential to be scaled up into national health programs throughout the world.5

At one meeting of a COPROMSA, one volunteer informed the others that he was planning to resign as his community's designated health promoter. A newly elected local authority was publicly trying to decrease community respect for his actions as health promoter. The other COPROMSA members gave him moral support, stressing all the good he had achieved in several years of community service. They convinced him his actions were of great value to his community and gave him advice on how to defuse the situation. In the end he was convinced to continue.

For more information on CARE's CS XII project in Peru, please contact:

- Namita Kukreja, Children's Health Program Associate, CARE: kukreja@care.org
- Luis Tam, CARE Peru: tam@carepe.org.pe

CARE Mozambique Results Highlight: "Theatre as a Behavior Change Tool"

Taking a cue from the success of the "Enter-Educate"* approach, one of the media channels chosen by the CARE Mozambique child survival project included establishing mobile theatre groups to present live theatre performances. Theatre in Mozambique is universally popular and used for education and entertainment alike-by government and the public sector as well as the private commercial sector. The project deliberately decided not to work with a professional group, choosing instead to host contests in the target districts to select willing volunteers. Two groups were thus organized, and participated in a highly successful first workshop in July 1998.

A renowned local performance artist transformed the rural inhabitants into a tightly knit team that continued to develop both professionally and personally throughout the two years of the project. In large part, the overwhelming success of the theatre interventions was due to the cohesiveness and dedication of the two groups. Each group had five to seven performers who were trained in both educational theatre techniques and a repertoire of six scenarios. A "soap opera" format was adopted, and the same characters appeared in different situations in each scenario.

The project deliberately decided not to work with a professional group, choosing instead to host contests in the target districts to select willing volunteers.

The team used the "Near Peer"+ model, where the principle characters in the play were drawn from a profile of the typical target group member, but enhanced with project desired behaviors. Project qualitative research was con-

* Johns Hopkins University/Population Communication Services, Baltimore, Maryland.
+ Academy for Educational Development, Washington, D. C.

sulted for this activity, as well as field visits to talk with some community people to discuss traits and personalities of people they admire. Target population members aspire to be like the "Near Peer," and can see the real possibility of changing their behavior.

Five training events were conducted over two years. Performance costs included transport, meal and lodging costs, and minimal costumes. Each training cost around $700, and one tour for four days cost approximately $180. Between the two health projects, 96 presentations were made, to a total of 18,972 spectators.

Accuracy on the message retention was 90 percent.

The Reproductive Health project conducted an exit interview activity at the end of one performance. Ten simple questions were asked regarding the key messages and the spectator's impression of the show. Accuracy on the message retention was 90 percent, and people were extremely enthusiastic about the spectacle.

It is the opinion of the project management that one of the benefits for the project is that the group members themselves have become very adept at communication, and involved in the welfare of their own community and of those that they visit.

While generally IEC promotional activities such as this are doomed as unsustainable, there is optimism for these groups. Already they have the sponsorship of the Reproductive Health project. The nutrition component of CARE's agriculture program will be linking with the groups to insert another show into their repertoire. The Provincial Health Department and the District Health Services have asked for their contacts and the terms of their work, so they too may continue to support them.

For more information on CARE's CS XII project in Mozambique, please contact:

- Namita Kukreja, Children's Health Program Associate, CARE: kukreja@care.org

Save the Children Guinea: Increasing births attended by trained personnel

High Maternal Mortality

When Save the Children began its health program in Mandiana, Guinea, approximately 1,600 women were dying for every 100,000 live births due to hemorrhage, infection, obstructed labor, and hypertension during pregnancy. This maternal death rate was one of the highest in the region and is attributed to several factors, including the lack of qualified health personnel and trained birth attendants, the difficult access to emergency obstetrical care, and the low level of knowledge of the danger signs in pregnancy and delivery by women and their families. The baseline knowledge, practice, and coverage survey in 1997 showed that 10 percent of births were assisted by trained health workers, and 26 percent by traditional birth attendants who had received some training. Untrained traditional birth attendants, husbands, or other family members delivered the other 64 percent of births. In addition some villages are over eight hours from the nearest reference hospital for emergency obstetrical care.

Project Progress

The project has surpassed its objective of increasing attended births by trained personnel from 36 percent to 83 percent (objective 70 percent). The proportion of pregnant women receiving at least two pre-natal contacts has increased from 45 percent at baseline to 65 percent (objective 75 percent). The project has introduced programmatic innovations that have been well accepted by both MOH/DPS and the community.

Technical assistance from the American College of Nurse Midwives through the PRIME/INTRAH project enabled SC to work with Directorate Préfectoral de Santé (DPS)/MOH to adapt the TBA training curriculum to include community-based life-saving skills. The project can be proud of the national-level acceptance of these curricular innova-

[1]The team looking into the MNC intervention visited 10 *caisses* and found that nine had been used to assist women in labor and repaymen had taken place.

tions by MOH and the progressive nature of the collaboration; and this should be considered a special outcome with future policy implications.

Seventy-three (73) traditional birth attendants (AVs) have been trained in clean delivery and are functioning as members of the VHCs in the 73 districts. In addition, 657 VHC members and 55 COGES (Health facility management committee) members have been trained in the importance of maternal and newborn care, danger signs, and birth plans. Transport systems and caisses de solidarité (community fund for emergencies), established to assist pregnant women in seeking essential obstetrical care (EOC) are functioning in all 73 districts[1]. In the 19-month period from October 1998 through July 2000, 4,282 women of reproductive age had participated in BCC activities focusing on the importance of pre- and post-natal care, danger signs, and birth planning.

The project has increased births attended by trained personnel from 36 percent to 93 percent.

At the facilities level, 44 MCH nurses have received refresher training in maternal and newborn care, including life-saving skills. Annual supervisory visits have been carried out and documented. The referral system for EOC will be strengthened soon by the installation of radios into the prefecture hospital (base) and 11 health centers and provision of a new ambulance by UNICEF, through the Projet Population Santé Genesique (PPSG), a channeling agent for donor funding attached to MOH. UNICEF will also re-equip the maternity at the hospital in Mandiana. The MTE team was told that UNICEF is supporting these improvements partly because of SC's strong presence in the prefecture. Again, the positive reputation that SC has built in Guinea in only four years is a strong point of the project worthy of special note.

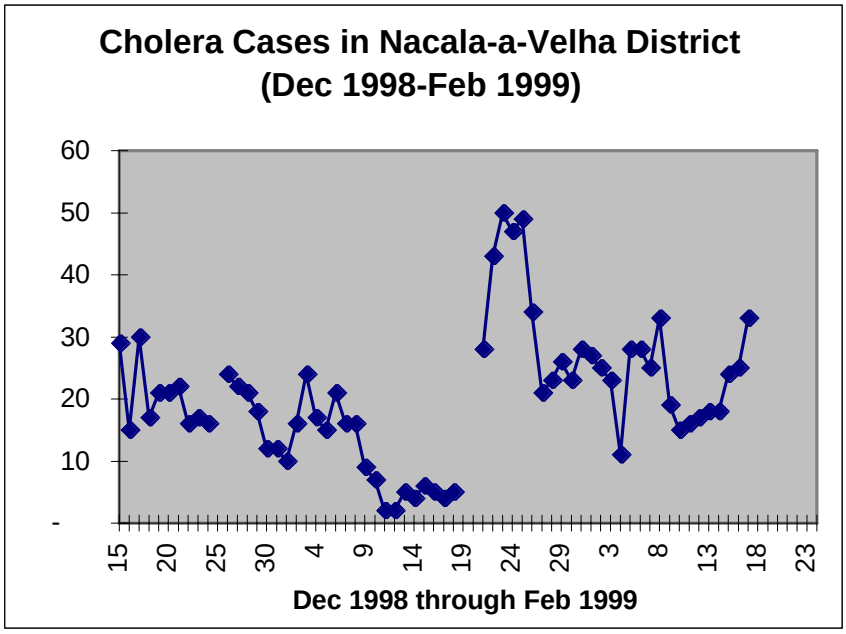
For more information on Save the Children's CS XIV project in Guinea, please contact:

- Program Coordinator Dr. Yacouba KANDE: savegnea@leland-gn.org (224) 71-07-25
- Eric Swedberg, SC/USA Child Survival Specialist: eswedber@savechildren.org

Save the Children Mozambique: Capacity-building During a Cholera Epidemic

Save the Children's (SC) Child Survival XII staff learned that one way to achieve capacity building and to improve working relations with local partners is to work side-by-side with them during a crisis. A cholera outbreak struck Memba and Nacala-a-Velha districts (and most of northern Mozambique) in October 1998. By February 1999, there were 4,853 cases and 198 deaths. From the start of the outbreak, SC conscientiously mobilized resources, including office staff, to fight cholera. The project:

- Facilitated assessment and supervision visits from the provincial level;
- Placed five vehicles on 24 hour call for supervision and transport;
- Converted its Mobile Brigade to assist in emergency work;
- Organized cholera training for district and project staff;
- Gave more than 200 health talks on cholera to 10,000 people;
- Worked side-by-side with district staff in the cholera treatment centers;
- Had primary responsibility for data collection and analysis;
- Purchased buckets, basins, beds, and rubber boots; and
- Procured salt and sugar when ORS packets ran out.



The response to this assistance was not always positive. The epidemic disrupted project supervision, training and baseline studies. Some health workers were accused of putting cholera (white poison) in the water, probably due to confusion between the word for bleach (cloro) and "cholera." Generally, the problems decreased when the community saw how the cholera treatment centers, in part manned by project staff, were saving lives.

Community members developed a high regard for project staff who were deeply involved in the cholera treatment centers where so many lives were saved.

There were also many positive developments. In Memba, communities with Activistas were not affected by cholera, perhaps due to greater mobilization of these communities. In Nacala-a-Velha, communities affected by cholera with Activistas had high levels of volunteer support. Community members developed a high regard for project staff who were deeply involved in the cholera treatment centers where so many lives were saved, leading to goodwill and making future community work much easier. Prior to the epidemic, working relationships with the districts were more parallel than collaborative.

During the epidemic, planning and evaluation sessions to mobilize and coordinate resources were held daily in Memba, and twice a week in Nacala-a-Velha. Working "in the trenches" with district staff was a capacity-building experience that continued after the epidemic. It also encouraged the expansion of capacity-building activities to the health facility and district levels as part of its follow-on CS-16 Project.

Through *The Nacala-a-Velha Child Survival Project*, staff learned that a project should stay flexible to respond to urgent short-term needs, rather than focusing narrowly on project activities. Such opportunities can improve capacity building of local partnerships and have a positive impact on long-term project outcomes.

For more information on Save the Children's CS XII project in Mozambique, please contact:

- Jeanne Koepsell, Program Manager, SC/Mozambique: jkoepsel@teledata.mz
- Eric Swedberg, SC/USA Child Survival Specialist: eswedber@savechildren.org

HOPE Peru: Cocoa fortified with heme iron: An effective strategy for combating iron deficiency anemia

HOPE Peru's Child Survival XII project implemented in the rural Amazon basin part of the country encountered a high level of anemia in women and children during the baseline study in 1997. The prevalence was 56 percent in children under three and 33 percent in women of reproductive age.

Because the main cause of anemia is iron deficiency, the findings spurred the project to find a way to increase the availability and consumption of iron. After researching various possibilities, the staff selected a fortified food offering a low cost, acceptable source of micronutrients for vulnerable families: cocoa.

A. Quijano	K. Alarcón	L. Diaz	B. Casanova
56% in 30 days	**50 % in 56 days**	**63 % in 56 days**	**100 % in 28 days**
Schoolchildren	**Adults-both sexes**	**Adults-both sexes**	**Women >14y**
With anti-parasite	**With anti-parasite**	**With anti-parasite**	

The final product was developed in four steps: formulation, acceptability testing, effectiveness testing, and marketing.

Formulation: The first step was to identify a locally available product that was compatible with fortification. Laboratory and cost studies evaluated physical characteristics of products, which offered approximately 150 percent of the daily requirement of a child at an affordable cost. Studies were made of cocoa, plantain flour and fudge. After examining plantain flour, cocoa was selected as the vehicle.

A document review of fortification indicated that the most acceptable and available product to provide iron would be Ferrimin, a cow's blood source of protein and iron produced in Chile. Ferrimin provides a source of iron, which is easy for the body to take up and use. The resulting product, fortified cocoa, consisted of 25 percent Ferrimin and 75 percent locally grown cocoa.

Acceptability: The formula underwent acceptability studies in four different products; cocoa mixed with water, mixed with milk, thickened with banana flour, and fudge. Men, women, and children took part in taste in both urban and rural areas. Fortified cocoa-flavored milk had an overall acceptability rate of 87 percent.

Effectiveness: Students from the University Peruana Cayetano Heredia carried out four studies in the project area on the effectiveness of the product in reducing anemia. A summary of the studies shows a high level of recuperation from anemia in various population groups:

Researchers concluded that cocoa fortified with Ferrimin had a high level of efficacy¾greater than a 50 percent rate of recuperation of anemia with one to two months of treatment. It is recommended that for use in treating iron-deficiency anemia, the cocoa be used in conjunction with an anti-parasite drug, particularly in rural tropical areas.

Marketing: The project developed a package of technical information on the efficacy and merits of fortified cocoa and made it available at no cost to small business entrepreneurs. Fortified cocoa is now available on the local market with limited distribution. The project continues with the challenge of acting as an intermediary to encourage the production and distribution to a wider market, particularly those most effected by under nutrition.

For more information on Project HOPE's CSXII project in Peru, please contact:

- Luis Benavente MD, MSc Associate Director MCH: lbenavente@projecthope.org
- Sandra Contreras RN, MPH, Peru Country Director: hopeperu@minsa-sm.gob.pe

HAI Mozambique BHR/PVC Child Survival Project Impact Report

HAI Child Survival Project

This project has focused on reducing perinatal, infant, child, and maternal mortality in Manica and Sofala Provinces (total population 2.4 million) in central Mozambique. The project interventions are Maternal and Newborn Care (40 percent), STD/AIDS (35 percent), and Malaria Control (25 percent). The project has been funded since 1998 by USAID/BHR/PVC, with additional support from the Finnish Development Agency, JSI, and UNICEF. All project activities are carried out jointly with Ministry of Health personnel; HAI technical staff all work with counterparts in the provincial health offices of both provinces.

General approach of the project includes the following:

- Increasing the quality of health services by
  - Strengthening supervision, management, evaluation, maintenance, and overall provision of services.
  - Training of health post staff in planning, management, and provision of population-based MCH/FP services via seminars, on-the-job training, supervised practice, and the development of manuals.
  - Enhancement of management systems at provincial, district, and health unit levels and reinforcement of systems to sustain improvements.
- Improvement of community-based health activities through health post-linked community leaders councils (CLCs) and street theater.

Target Areas:

Manica and Sofala Provinces in Central Mozambique (population 2.4 million)

Project Offices:

Beira and Chimoio, Mozambique within the Provincial Offices of the Ministry Health

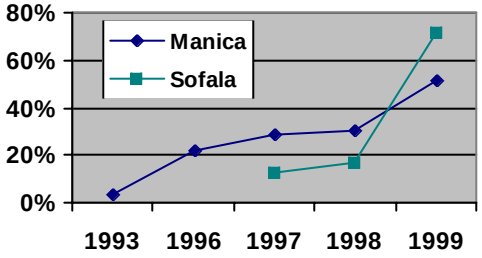
Selected Impact Measures

MATERNAL-NEWBORN CARE

Prenatal care quality improvement:

- Over 90% of pregnant women attended prenatal care, with an increase in early attendance
- Increased antenatal syphilis screening in Manica and Sofala Provinces from 3-4% (1995) to over 70% (1999)-see chart *(5400 women screened per month)*
- Identified and treated over 7000 Rapid Plasma Reagent (Screening test for syphilis) positive women *(13% have been RPR positive)*
- Contacted and treated over 4000 partners
- Reduction in stillbirth rate in Manica Province from 50 to 35 per 1000 births

Percent of women in prenatal care screened for syphilis

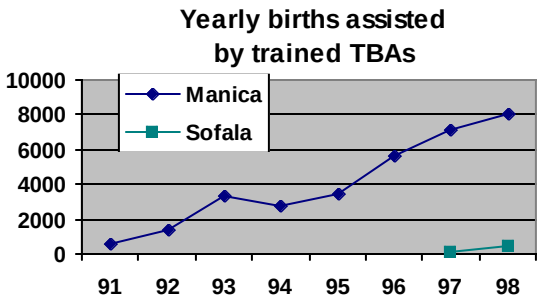


MATERNAL-NEWBORN CARE

Birth Attendance:

- Over 300 traditional birth attendants (TBAs) trained, provided quarterly supervision and supplies and annual refresher workshops
- 9000 births annually attended by the trained TBAs (over 30,000 since 1992)

- Equipped, trained, and supervised health sector midwives in over 34 health posts
- An estimated 56% of all births in Manica province are attended by trained providers
- Obstetric emergency plan developed by PAC (The Cultural Activists Program Theatre Group)



Malaria Control

- Drug resistance studies completed in three sites of two provinces
- Community-based fever treatment study carried out in both provinces, published, and presented
- Bednet availability study carried out in Sofala Province
- Pilot implementation of bednet promotion schemes initiated in two districts of Sofala
- Malaria play developed by PAC and presented to many communities

STD/AIDS CONTROL

School, adolescent activities

- Sixteen Middle and secodary school AIDS clubs started, teachers trained
- Four youth-friendly health and coun selling facilities opened

Sex worker activities

- Peer education for sex workers begun in Beira and expanded in Chimoio
- Night STD clinic opened in Beira for sex workers and clients

Community Leaders Councils (CLCs)

- CLCs have been trained in STD/AIDS control
- Community AIDS plans initiated
- Condoms, gloves available at all health facilities

ALL INTERVENTIONS

Community IEC and health facility link:

- Cultural activist groups have created and presented maternal care, STD/AIDS, and malaria plays
- Cultural activist groups developed, supported, and made presentations which reached 26,000 mothers in seven months of 1999
- Community-health sector integrated workshops carried out in all districts of Manica Province (three in Sofala) annually since 1998
- New health education materials developed for Provinces and MISAU
- Health data analysis workshops carried out with CLCs in all districts in Manica Province and four districts in Sofala Province in 1999

For more information on HAI's CS XIV project in Mozambique, please contact:

- Stephen Gloyd, HAI: gloyd@u.washington.edu

World Relief Nicaragua: Reaching Communities and Families

The World Relief Child Survival XII project area lies within the Department of Río San Juan (RSJ) and the South Atlantic Autonomous Region (RAAS) in Southeastern Nicaragua. It covers a total of 34,880 square kilometers. Although these departments share a common border, there are no roads or highways directly linking the two.

This project is located in an extremely difficult area, and working conditions are hard. It is hot and humid all year long and the rainy season lasts for six months. Most of the target communities are not accessible by road. They are so isolated that project staff members must walk five to seven hours to reach them. Many communities are only accessible by riverboat.

Despite these conditions, the project staff met 100% of their goals under very difficult working conditions. The interventions of children eating foods rich in vitamin A, prenatal visits, eating more food when they have diarrhea, the use of ORT, and child immunizations had the greatest impact in this project. Four of these five interventions substantially surpassed the goals and were adopted by 70% or more of the population. This is evidence that the project staff and community volunteers effectively reached the vast majority of the women in the project area.

Coverage of mothers of childbearing age was nearly 100% for all of the intervention areas. This is significant because of complicated access to the communities. The Promoters (paid staff) faithfully accomplished their mission.

It is possible to make substantial progress in controlling diarrheal diseases in rural, tropical areas. In the first several years the project, staff despaired of making progress in this area, but by the end of four years over 70% of mothers were successfully treating these diseases at home.

The goal for exclusive breastfeeding was surpassed by 200%. This is an area in which it is difficult to obtain behavior change. One of the factors that contributed to this success was the diligence of the Promoters and Brigadistas in personally visiting mothers during pregnancy and in the months after delivery. In the rural areas, home visits were the only reasonable setting for education. Group learning sessions were almost impossible to organize because of distances between homes and the difficulty in walking almost anywhere. The Promoters and Brigadistas should be commended for their hard work in making sure that each mother received monthly visits pre- and post-partum.

One of the factors that contributed to this success was the diligence of the Promoters and Brigadistas in personally visiting mothers during pregnancy and in the months after delivery.

In the urban areas of Bluefields the project staff were able to organize breastfeeding support groups. By the end of the project over 240 mothers were participating in 12 support groups. An important indicator of the commitment that mothers had to these groups is that all of the volunteer support groups' leaders have continued for two years. No volunteer leader has dropped out. In contrast, the turnover rate with the community health volunteers, the Brigadistas, was very high.

Of women who were interviewed by the evaluation team, the women in the breastfeeding support groups were the most articulate and analytical of all. It appears that the mothers were highly motivated and invested themselves in the learning process.

Another area in which the project made great progress was in family gardens. Their information system recorded that 1,265 homes had family gardens. In the last year the staff focused on this intervention. The promoters did cooking demonstrations of recipes that used locally available foods, in conjunction with promoting gardening. These experiences were fresh on people's minds and they made

An important indicator of the commitment that mothers had to these groups is that all of the volunteer support groups' leaders have continued for two years.

frequent references to gardening in the final evaluation interviews.

In response to challenges, the project staff used an individual approach for reaching people. As expressed earlier, the Promoters worked hard to reach the communities and to visit at-risk families. This is one of the reasons why the mid-term evaluation team recommended that the number of targeted communities be cut in half. By doing so, they were able to visit each community and the corresponding at-risk homes at least once a month. In the end this approach paid off with strong outcomes.

For more information on World Relief's CS XII project in Nicaragua, please contact:

- Dr. Donald Weil, Child Survival Project Director, World Relief Nicaragua (for communication in Spanish): wrnbluefields@xerox.com.ni
- Melanie Morrow, Child Survival Program Specialist: mmorrow@wr.org.

World Relief Cambodia: Success through Care Groups

The project serves five communes (the northern section) of Ponhea Kriek District in Kompong Cham Province. It is located about a five hour drive north and east of Phnom Penh, on the Ho Chi Minh trail, close to the border of Viet Nam.

The desertion rate of volunteers is less than 10 percent. This is outstanding, especially considering that there are over 900 volunteers.

The project is working in four interventions: birth spacing, diarrhea management, nutrition (iron, iodine, vitamin A, breastfeeding) and immunizations.

The project's main accomplishments are summarized below.

- The immunization rates for children have risen from 5 percent to 28 percent and for toxoid tetanus for women from 2 percent to 31 percent. This implies a strengthening of the MOH's capacity, as well as the large percent increase in beneficiaries.
- The desertion rate of volunteers is less than 10 percent. This is outstanding, especially considering that there are over 900 volunteers. The care group system for organizing the volunteers is very effective.
- Teaching about washing hands before cooking and after using the toilet has been effective. Fifty-seven percent of households have a hand washing station and 34 percent of the women report washing their hands before cooking. This is a difficult behavior to change; the project staff has made good progress.

An important innovation in this project is the way volunteers have been organized into Care Groups. Fourteen field staff supervise 930 volunteers. Village health volunteers are grouped together into care groups of seven to eight volunteers each. Each volunteer is responsible for 15 families in their immediate neighborhood.

Each field staff member is responsible for nine care groups, and visits them each month. They have enough time to spend a whole day in a care group catchment area. This means the promoter can meet with the care group for project business (one to two hours) and then still have several hours free to visit with two to three volunteers and observe their interactions, help with difficulties, etc. Field staff can often meet with one or two care groups per day, which means they can meet with all their groups in the first three weeks of the month.

Their ability to organize, train and sustain such a large group of volunteers is unexpected in Cambodia. Some had even counseled WR that extensive reliance on volunteers would not work. Nevertheless WR has been unusually successful in training 930 volunteers and in achieving a dropout rate of only 10 percent a year.

WR has been successful for several reasons. The group dynamics provide interpersonal support that is not dependent on the presence of the field staff. Because of this they meet on their own to help each other learn, to plan and to socialize. Many of the volunteers report that they have never had this kind of experience and they are happy to be volunteers just for the benefit of being part of a group.

The group dynamics provide interpersonal support that is not dependent on the presence of the field staff.

The second reason is that the volunteers associate their group training meetings with having fun. Much of the volunteer training has been done through drama and puppets and this has been a new source of entertainment (besides learning!) for them.

For more information on World Relief's CS XIV project in Cambodia, please contact:

- Melanie Morrow, Child Survival Program Specialist: mmorrow@wr.org

The Living University...

continued from page 2

activities to government health services. Following CS-14 expansion into two new areas, two of the current LR CDAs will become LU CDAs to build capacity of two new LR CDAs.

In CS-14, CDAs and CHWs have been particularly effective in increasing antenatal visits and tetanus immunization. Before CDAs had taken up the issue with local health services, it had been common practice for pregnant women not to be registered or receive ANC booklets unless they were at least four months pregnant. CDAs where informed of this practice by CHWs who learned during their work about community concerns regarding the quality of ANC services at health facilities. Following several meetings in which CDA members and SC staff brought these issues to the attention of health facility staff, the number of ANC visits has increased 265 percent, TT immunizations by 67 percent, and pregnant women now receive ANC booklets during their first visit to a health facility. Joint problem solving by CDAs and district health staff has also led to several other improvements, including a closed health facility being opened and staffed. SC-supported CDAs are now writing proposals and receiving funds for community development activities from other donors, suggesting important implications for the sustainability of this approach.

Following several meetings in which CDA members and SC staff brought these issues to the attention of health facility staff, the number of ANC visits has increased 265 percent.

For more information on Save the Children's CS XIV project in Egypt, please contact:

- Eric Starbuck, SC/USA Child Survival Specialist: tarbuck@dc.savechildren.org
- Samir Khamis, Project Director: skhamis@savechildren.org.eg or Save the Children's Cairo office at 011-202-356-3510

A Note on Participatory Methodology in Mid-term and Final Evaluations

Child Survival projects are required to conduct mid-term and final evaluations with guidance from an external facilitator or evaluator. These events provide important opportunities for developing M&E capacity and "learning organization" skills with project stakeholders, especially with the project staff and staff of the local partners who are working to improve child and maternal health at the local level.

Participatory Evaluation involves strengthening critical thinking and sharing concerns and suggestions. In its fullest execution, the participatory evaluation approach involves these stakeholders in the design of research questions and data gathering.

> *Prior to the arrival of the consultant] the regional Health Advisor went to work with the evaluation team and trained them in the participatory methodology. The four-day training course was very intense, and readied the team for the evaluation. The team then began some data collection in the presence of the trainer, which furthered the capacity- building process among the evaluation team. Thus, the MTE was not only an assessment of the project to date, but it contributed to the project's goals of increasing the skills of SC staff and MOH staff as well.*
>
> -From Save the Children's Tajikistan's Mid-term Evaluation Report on the participatory methodology used in that evaluation

The first issue of CS Connections featured the participatory evaluation methodology as a promising practice for increasing active collaboration and use of information by project teams. A recent review by CSTS reveals an increase in the use of the methodology. Eight of the 17 project final evaluation documents reviewed for the year 2000 indicate that a participatory approach was adopted; a large number of project and partner staff were involved in designing and carrying out the evaluation, not just participating as information providers, interviewers or interviewees.

The projects which reported using a participatory evaluation approach include HKI Niger, HOPE Peru, World Vision Cambodia and Zambia, IEF/CCF Ethiopia (where the consultant worked with two national independent consultants), World Relief Nicaragua, and CARE Haiti. SAVE Mozambique reported that a large team was involved in the evaluation, and the consultant confirmed that this team was included in all aspects from the research design to the data analysis.

If you have any questions regarding the use of a participatory methodology in project evaluations, please contact someone from the projects mentioned above and ask them to share to share their experiences with you.

Child Survival
CONNECTIONS

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To submit an article to be published in CS Connections, please contact Rikki Welch at (301) 572-0466 or rwelch@macroint.com.

Rikki Welch, Editor

CS Connections can be found online at www.childsurvival.com.